TEXT OF PROPOSED REGULATIONS

Risk-Bearing Organizations – Financial Solvency

TEXT OF PROPOSED CHANGES
TO THE REGULATIONS UNDER THE
KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975

1. Adopt sections 1300.75.4 through 1300.75.4.6, California Code of Regulations, Title 28, to read:

Risk-Bearing Organizations

1300.75.4. Definitions.

As used in these solvency regulations:

(a) "External party" means the Department of Managed Health Care or its designated agent, which may be an outside entity or person contracted or appointed to fulfill the functions stated in these solvency regulations. Whenever these solvency regulations reference the Department of Managed Health Care, that reference means the Department of Managed Health Care or its designated agent, which may be an outside entity or person contracted by the Department of Managed Health Care to fulfill the stated function.

(b) "Organization" means a risk-bearing organization as defined in subdivision (g) of Health and Safety Code Section 1375.4.

(c) “Plan” means full-service health care service plan, as defined by Health and Safety Code Section 1345(f).

(d) “Risk arrangement” shall include both “risk-sharing arrangement” and “risk-shifting arrangement,” which are defined as follows:

(1) "Risk-sharing arrangement" means any compensation arrangement between an organization and a plan under which both the organization and the plan share a risk

of financial loss.

(2) "Risk-shifting arrangement" means a contractual arrangement between an organization and a plan under which the plan pays the organization on a fixed, periodic or capitated basis, and the financial risk for the cost of services provided pursuant to the arrangement is assumed by the organization.

(e) "Solvency Regulations" means California Code of Regulations, Title 28, Regulations 1300.75.4 through 1300.75.4.6.

NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.

1300.75.4.1. Risk Arrangement Disclosure.

(a) Every contract involving a risk arrangement between a plan and an organization shall require the plan to do all of the following:

(1) Disclose through electronic transmission (or in writing, if agreeable to both the organization and the plan) to the organization, on a monthly basis, beginning with the month of May, 2001, within 10 calendar days of the beginning of each report month, the following information for each enrollee assigned to the organization: member identification number, name, birth date, gender, address, plan contract selected, employer group identification, any other third party coverage, if known to the health plan, enrollment/disenrollment dates, medical group/IPA number, provider effective date, type of change to coverage, co-payment, deductible, the amount of capitation to be paid per enrollee per month, and the primary care physician when the selection of a primary care physician is required by the plan.

(2) Disclose through electronic transmission (or in writing, if agreeable to both the

organization and the plan) to the organization, on a monthly basis, beginning with the month of May, 2001, within 10 calendar days of the beginning of each report month, the names, member identification numbers, and total numbers of enrollees added or terminated under each benefit plan contract served by the organization.

(3) Disclose, as part of the contract with the organization, for the purpose of assisting the organization to be informed regarding the financial risk assumed under the contract, the following information for each and every type of risk arrangement (Medicare+Choice, Medi-Cal, traditional commercial, Point of Service, small group, and individual plans) under the contract:

(A) a matrix of responsibility for medical expenses (physician, institutional, ancillary, and pharmacy) which will be allocated to the organization, facility, or the plan under the risk arrangement;

(B) expected/projected utilization rates and unit costs for each major expense service group (inpatient, outpatient, primary care physician, specialist, pharmacy, home health, durable medical equipment (DME), ambulance and other), the source of the data and the actuarial methods employed in determining the utilization rates and unit costs by benefit plan type for the type of risk arrangement; and

(C) all factors used to adjust payments or risk-sharing targets, including but not limited to the following: age, sex, localized geographic area, family size, experience rated, and benefit plan design, including copayment/deductible levels.

(4) Beginning with the first quarter of calendar year 2001, disclose through electronic transmission (or in writing, if agreeable to both the organization and the plan) to the organization, on a quarterly basis, within 45 calendar days of the close of each quarter, a detailed

description of each and every amount (including expenses and income) allocated to the organization and to the plan under each and every risk-sharing arrangement.

(5) Provide payments of all risk arrangements, excluding capitation, no later than 180 days after the close of the organization's contract year, or the contract termination date, whichever occurs first.

(b) In addition to the disclosures required by subsection (a) of this regulation, every contract involving a risk-sharing arrangement between a plan and an organization shall require the plan to disclose, as part of the contract, the amount of payment for each and every service to be provided under the contract, including any fee schedules or other factors or units used in determining the fees for each and every service. To the extent that reimbursement is made pursuant to a specified fee schedule, the contract shall incorporate that fee schedule by reference, including the year of the schedule. For any proprietary fee schedule, the contract must include sufficient detail that payment amounts related to that fee schedule can be accurately predicted.

(c) In addition to the disclosures required by subsection (a) of this regulation, every contract involving a risk-shifting arrangement between a plan and an organization shall require the plan to disclose, as part of the contract, in the case of capitated payment, the amount to be paid per enrollee per month. For any deductions which the plan may take from any capitation payment, details sufficient to allow the organization to verify the accuracy and appropriateness of the deduction shall be provided.

NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.

1300.75.4.2. Organization Information.

Every contract involving a risk arrangement between a plan and an organization shall require the organization to do all of the following:

(a) For each quarter beginning on or after January 1, 2001, (for an organization that begins its fiscal quarter on January 1, 2001, the first submission is due by May 15, 2001), submit to the Department of Managed Health Care or its designated agent, not more than forty-five (45) days after the close of each quarter of the fiscal year, a quarterly status report containing all of the following:

(1) Financial statements (including at least a balance sheet, an income statement, and a statement of cash flows), or comparable financial statements in the case of a nonprofit entity, for the immediately preceding quarter prepared in accordance with generally accepted accounting principles (GAAP).

(2) A statement as to what percentage of claims have been reimbursed, contested, or denied during that quarter by the organization within 45 working days, and in accordance with the other requirements of Health and Safety Code Sections 1371 and 1371.35, and in accordance with any other applicable state and federal laws and regulations. If less than 95% of all claims have been reimbursed, contested or denied on a timely basis, the statement shall be accompanied by a report that describes the reasons why the claims-paying process is not meeting the requirements of applicable law, any action taken to correct the deficiency, and any results of that action.

(3) A statement as to whether or not the organization has estimated and documented, on a monthly basis, its liability for incurred but not reported (IBNR) claims, pursuant to a method specified in Regulation 1300.77.2, and that these estimates are the basis for the financial

statements submitted under these solvency regulations. If the estimated and documented liability has not met the requirements of Regulation 1300.77.2 in any way, the statement shall be accompanied by a report that describes in detail the following with respect to each deficiency: the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.

(4) (A) A statement as to whether or not the organization (i) has at all times during the quarter maintained a positive tangible net equity ("TNE"), as defined in Regulation 1300.76(e); and (ii) has at all times during the quarter maintained a positive level of working capital, calculated in a manner consistent with generally accepted accounting principles (GAAP). If either the required TNE or the required working capital has not been maintained at all times, the statement shall be accompanied by a report that describes in detail the following with respect to each deficiency: the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.

(B) The organization may reduce its liabilities for purposes of calculating its tangible net equity and working capital in a manner allowed by Health and Safety Code Section 1375.4(b)(1)(B). For purposes of Health and Safety Code Section 1375.4(b)(1)(B), a sponsoring organization shall have a tangible net equity of at least twice the total of all amounts that it has guaranteed to all persons or entities, or a tangible net equity in an amount approved by the Director of the Department of Managed Health Care, in situations where the organization can demonstrate to the Director's satisfaction that a lesser amount is sufficient.

(5) A written verification attached to each report made under paragraphs (1), (2), (3) and (4) of this subsection stating that the report is true and correct to the best knowledge and

belief of a principal officer of the organization, and signed by a principal officer, as defined by regulation 1300.45 (o) of Title 28 of the California Code of Regulations.

(b) (1) If the organization served at least 10,000 lives under all risk arrangements as of December 31, 2000, submit to the Department of Managed Health Care or its designated agent, not more than one hundred eighty (180 days) after the close of the organization's fiscal year beginning in year 2000, and, regardless of the number of lives served under all risk arrangements, submit to the Department not more than one hundred twenty (120) days after the close of the organization's fiscal year beginning on or after January 1, 2001, and not more than one hundred twenty (120) days after the close of each of the organization's subsequent fiscal years, an audit report prepared by an independent certified public accountant in accordance with generally accepted auditing standards, containing all of the following:

(A) Audited financial statements (including at least a balance sheet, an income statement, a statement of cash flows, and footnote disclosures), or comparable financial statements in the case of a nonprofit entity, for the immediately preceding fiscal year, prepared by the independent certified public accountant in accordance with generally accepted accounting principles (GAAP). For purposes of determining the independence of the certified public accountant, the regulations of the California State Board of Accountancy (Division 1, Sections 1 through 99.2, Title 16, California Code of Regulations), shall apply.

(B) An opinion of the accountant indicating that the financial statements submitted to the Department present fairly, in all material respects, the financial position of the organization, and that the financial statements were prepared in accordance with generally accepted accounting principles (GAAP).

(2) If the organization served fewer than 10,000 lives under all risk arrangements as of December 31, 2000, submit to the Department of Managed Health Care or its designated agent, not more than one hundred eighty (180 days) after the close of the organization's fiscal year beginning in year 2000, an accountant's report on a review including a statement of limited assurance that the financial statements are in accordance with generally accepted accounting principles (GAAP) or some other comprehensive basis of accounting approved by the Director as equally accurate and reliable as GAAP. The accountant's report on a review must cover all of the following:

(A) Reviewed financial statements (including at least a balance sheet, an income statement, a statement of cash flows, and footnote disclosures), or comparable financial statements in the case of a nonprofit entity, for the immediately preceding fiscal year, prepared by the independent certified public accountant in accordance with generally accepted accounting principles (GAAP) or some other comprehensive basis of accounting approved by the Director as equally accurate and reliable as GAAP. For purposes of determining the independence of the certified public accountant, the regulations of the California State Board of Accountancy (Division 1, Sections 1 through 99.2, Title 16, California Code of Regulations), shall apply.

(B) An opinion of the accountant indicating limited assurance that the financial statements submitted to the Department were prepared in accordance with generally accepted accounting principles (GAAP) or some other comprehensive basis of accounting approved by the Director as equally accurate and reliable as GAAP.

(c) Submit to the Department of Managed Health Care or its designated agent, a "Statement of Organization," to be filed with the organization's initial quarterly filing, and with

each annual filing made in subsequent years, which shall include the following information, as of December 31 of each calendar year prior to the filing:

(1) Name and Address of the Organization;

(2) Contact Person, with Title, Address, Phone, Fax, and e-mail address;

(3) A list of all Health Plans with which the organization has risk arrangements;

(4) Whether the Organization is an Independent Practice Association (IPA), Medical Group, Foundation, other entity, or some combination;

(5) Whether the Organization is a professional corporation, partnership, not-for-profit corporation, sole proprietor, or other form of business;

(6) A matrix listing all major categories of medical care offered by the organization, including but not limited to, primary care, cardiology, orthopedics, ophthalmology, oncology, and radiology, and next to each listed category in the matrix, a disclosure of the compensation model (salary, fee-for-service, capitation, other) used by the organization to compensate the majority of providers of that category of care;

(7) An approximation of the Number of Enrollees served by the Organization under a risk arrangement, pursuant to a list of ranges developed by the Department;

(8) Any Management Services Organization (MSO) that the organization contracts with for administrative services;

(9) Number of in-network contracted Physicians in the organization;

(10) Disclosure by California County or Counties of the Organization's primary service area (excluding out-of-area tertiary facilities and providers);

(11) Any other information which the Director deems reasonable and necessary to understand the operational structure and finances of the organization.

(d) Notify the Department of Managed Health Care or its designated agent no later than five (5) business days from discovering that the organization has experienced any event which materially alters its financial situation, or threatens its solvency.

(e) Permit the Department of Managed Health Care or its designated agent to make any examination that it deems reasonable and necessary to implement Health and Safety Code Section 1375.4, and provide to the Department, upon request, any books or records that the Department deems relevant to implementing this section, for inspection and copying.

NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.

1300.75.4.3. Plan Reporting.

(a) Every plan that contracts with an organization shall, by May 15, 2001, for the first quarter of calendar year 2001, and not more than forty-five (45) days after the close of each subsequent quarter, submit a report to the Director listing all its contracting organizations, including their names, addresses, contact persons, telephone numbers, and number of enrollees assigned to the organization as of the last day of the quarter being reported.

(b) For the quarterly report due May 15, 2001, and for the report due within 45 days after the close of the first quarter of each subsequent year (i.e., an annual reporting period), every plan must provide to the Director, the following information, as of December 31 of the prior calendar year, for each organization with which the plan has a risk arrangement:

(1) For the plan's commercial, Medicare+Choice, and Medi-Cal product lines, the report shall disclose, in a separate matrix for each product line, the allocation of risk between the

plan, the organization, and the facility by major expense category. For each of the plan's commercial, Medicare+Choice, and Medi-Cal product lines, the report shall disclose the number of covered lives.

(2) The report shall disclose whether the plan provides stop-loss insurance to the organization, and if so, the nature of any and all stop-loss arrangements.

(c) Each report or matrix submitted to the Department shall include a written verification stating that the report or matrix is true and correct to the best knowledge and belief of a principal officer of the plan, and signed by a principal officer, as defined by regulation 1300.45 (o) of Title 28 of the California Code of Regulations.

(d) Upon request, the plan shall provide any additional information that the Director may from time to time require to understand the type, amount, or appropriateness, of the financial risk assumed by the plan's organizations.

(e) Every plan that contracts with an organization shall have adequate procedures in place to ensure that the plan notifies the Department of Managed Health Care or its designated agent no later than five (5) business days from discovering that any of its organizations experienced any event which materially alters the organization's financial situation, or threatens its solvency.

NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.

1300.75.4.4. Confidentiality.

The Director shall provide for the confidentiality of financial and other records to be produced, disclosed, or otherwise made available pursuant to Health and Safety Code Section 1375.4, and to these solvency regulations, unless the Director determines otherwise.

NOTE: Authority cited: Sections 1344, 1375.4(b)(7), and 1375.4, Health and Safety Code. Reference: Sections 1375.4 and 1375.4(b)(7), Health and Safety Code.

1300.75.4.5. Plan Compliance.

Any failure of a plan to comply with the requirements of Health and Safety Code Section 1375.4 and these solvency regulations shall constitute grounds for disciplinary action against the plan. The Director may seek and employ any combination of remedies and enforcement procedures provided under the Act, to enforce Health and Safety Code Section 1375.4 and these solvency regulations.

NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.

1300.75.4.6. Department Costs.

The Department's costs incurred in the administration of Health and Safety Code Sections 1347.15 and 1375.4 shall come from amounts paid by plans, except specialized plans, pursuant to Health and Safety Code Section 1356.

NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Sections 1347.15, 1356 and 1375.4, Health and Safety Code.